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REMARKS ON DRAINAGE FOLLOWING ABDOMINAL SECTION.*

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It appears to me that no exaggeration is made when the statement is advanced that the tendency of the day in surgery is to as much as possible eliminate drainage, and that experience is daily proving that this procedure is less and less necessary in abdominal surgery. Ideal surgery is that surgery which permits the surgeon to close tightly all wounds in such a manner that there will be need of no after-treatment or dressing. The nearer one can approach this desideratum the nearer he approaches perfect surgery, and any tendency which leads one away from the accomplishment of this is faulty, and is to be tolerated only as a necessary evil. Such is drainage—it is a necessary evil in abdominal surgery, and becomes the more necessary in proportion to the lack of skill or judgment brought to the case by the individual surgeon. It is a notorious fact that there are surgeons of equal skill, working with the same facilities and on the same class of cases, and yet one will use drainage in from 50 to 75 per cent. or more of his cases while his neighbor will be using it in only from 5 to 10 per cent. or even less. The question naturally arises, what is the difference in results as between two such men? One would naturally imagine a comparison in such a case would quickly settle the matter pro or con. It is just such comparisons which are rapidly crystallizing surgical sentiment against drainage, excepting in exceptional cases. Compare, for instance, the work of any ten recognized leaders in abdominal surgery in Philadelphia, the one using drainage freely and the other practically not using it at all—there are several such examples open for comparison in this city. What is the result? As far as mortality is concerned, especially in the case of septic deaths, the advantage lies rather with non-drainage. But lest there be any dispute or quibble on that point, let us say, for the sake of the argument, that there is no difference, the range of mortality is about equal. This, I think, no one who is at all cognizant of the facts as they stand to-day, will venture to gainsay, otherwise I can assure him he is woefully lacking as

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to the true, plain facts which are within his reach any time he may take the trouble to investigate them. Granting then that the mortality is equal, is not the question settled most emphatically against drainage as a routine practice? He who has run the gauntlet of caring for a drainage tube or caring for and removing a gauze drain will in the majority of instances accept it as a thing of the past. He who has seen fistula after fistula follow its use will breathe a sigh of relief. He who has felt with a certain degree of uneasiness that a large portion of his resulting wound hernias have been due to the drainage tube will gladly in future dispense with its use.

Drainage has been so strongly and systematically preached during the past decade that in abdominal surgery it has taken deep root, and will no doubt be hard to eliminate from one's work. I can well remember with what trepidation I closed wounds and returned patients to bed when I became convinced that I was using drainage with unnecessary frequency and determined to make the effort to in part at least eliminate it from my practice; how, as I advanced, my confidence became greater and greater until to-day it is the exceptional case I drain—certainly not more than 5 per cent. My working rule has become, "when in doubt do not drain." The result has been that since I have practically ceased to drain I have not seen a fistula occur nor do I know of but one or two hernias during the past three years' work. The relief from the care of and anxiety over the tube has been simply immense—so great in fact, that the circumstances would have to be exceptionally strong which would force me back to the old practice. The free suturing of all wounds with catgut, and thus rendering all traumatisms extra peritoneal and at the same time getting rid of oozing to as great an extent as possible has helped to eliminate the necessity of drainage. The adoption of the Trendelenburg position in operating has not merely facilitated this but has rendered it possible in cases where it otherwise would not have been so. Even with a considerable amount of oozing no fear need be entertained, as not only practice but experimentation has amply proven the ability of the peritoneum to care for and dispose of a very considerable amount of fluids as well as solids.

Drainage, like the clamp in ovarian cysts and the *serre-nœud* in hysterectomy for fibroid tumors has been in the evolution of abdominal surgery a necessary evil—an evil which like the others, has in great part ceased to exist. We cannot entirely dispense with drainage, but he who drains over 5 or 10 per cent. of his cases takes unnecessary trouble and risk and in future will probably see this percentage lowered.

It will probably, and with justice, be demanded that my results be given in view of my emphatic and radical departure from the practice of the past. As an encouragement for those who are disposed to rid themselves of the evils and annoyances of drainage, I may state that since resuming my work last September after the summer's vacation (a period of six months), I have drained but three times, twice with gauze and once with glass. In two of these cases I should again drain had I to do over. One was in the case of an acute puerperal pelvic abscess in a moribund woman—abscess opened, emptied, washed out and drained. The other case was one of old, longstanding double ovarian abscesses and pyosalpinx with a long-standing bowel fistula and periodic discharges of pus from the rectum. This case was drained with gauze as a precaution lest the closure of the bowel opening should not prove secure. The precaution was well taken, as a temporary fecal fistula formed. The third case drained was a doubtful retroperitoneal condition. At the time it was considered to be possibly malignant. Drainage was a mistake in this case, and would not be repeated had I the operation to again perform. In the six months' work there was but one death, in either private or hospital work, all classes of abdominal surgery being included—that death being in the case of the acute puerperal patient already quoted, and which was drained. There has not been a single non-drainage death in this time.

This record is my answer to any one criticising my remarks on drainage. It appears to my own mind at least to fully justify what I have had to say on this subject, and my hope and object in publishing it is that it may be of encouragement to others who may be disposed to follow in my footsteps as I have followed in the footsteps of others.